

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2385-63-016276

2385

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED MAY 6 1963

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Henry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>5 yrs</b>	c. CITY OR TOWN <b>Calhoun</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3732 Paseo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rural Route</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>James E Slack</b>			4. DATE OF DEATH Month: <b>April</b> Day: <b>16</b> Year: <b>1963</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1874</b>	9. AGE (last birthday) <b>88</b>	IF UNDER 1 YEAR Months: Days: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farming</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Calhoun, Mo</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>					

13a. FATHER'S NAME <b>Henry Slack</b>		13b. MOTHER'S MAIDEN NAME <b>Martha P. Carter</b>		14. NAME OF HUSBAND OR WIFE <b>Edna Slack</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>no</b>		16. SOCIAL SECURITY NO. <b>6348</b>		17. INFORMANT <b>Earl Slack Aberdeen Prunty Ground</b> Address <b>Md</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO (b) <b>Senility</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Cirrhosis liver</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour: <b>6:50 PM</b> Month, Day, Year: <b>April 16 1963</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Calhoun</b> COUNTY <b>Mo</b> STATE <b>Mo</b>	

21. I attended the deceased from <b>1958</b> to <b>1963</b> and last saw her alive on <b>April 16 1963</b> Death occurred at <b>6:50 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>James E. Griffin, Jr.</b> (Degree or title)		22b. ADDRESS <b>3900 Paseo K. C. Mo</b>		22c. DATE SIGNED <b>4/17/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/19/1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calhoun cemetery</b>	
23d. LOCATION (City, town, or county) <b>Calhoun</b>		23e. STATE <b>Mo</b>			

24. FUNERAL DIRECTOR <b>Sickman &amp; Dunning F H Clinton, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>4-22-63</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF James E. Griffin, Jr., MEDICAL CERTIFICATION

ITEM NO.

SHOULD READ

INSTEAD OF

DATE AMENDED

VS 300  
Rev. 4/59

1  
20420

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Robert L. Dunning*

Licensed Embalmer No.

*4510*

P. O. Address

*Clinton MO*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.